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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2538 CERTIFICATE OF DEATH

02515

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>99 Washington Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jonathan</u> Middle <u>Baker</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 21, 1906</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>		IF UNDER 24 HRS. Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Midland, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Broderick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>Mrs. Julia Baker</u> Address <u>Frostburg, Md.</u>			
17. INFORMANT <u>Wife</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>with myocardial insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4-5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mild diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>3-29</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> 19 <u>61</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>H.C. Diehl</u>				22b. DATE SIGNED <u>3/30/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>				22d. ADDRESS <u>FROSTBURG, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u> ADDRESS <u>Lonaconing, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>C. L. Huns</u>			

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2539

02516

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2/21/61</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Euvonia</b> Last <b>Barnard</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> , Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife &amp; Sec.</b>		11. BIRTHPLACE (State or foreign country) <b>Oldtown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis Darkey</b>				14. MOTHER'S MAIDEN NAME <b>Laney Matilda Shryock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>				16. SOCIAL SECURITY NO. <b>175-18-4734</b>			
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>2/21/61</b> 19 to <b>3/14/61</b> 19, that (I) (we) last saw the deceased alive on <b>3/13/61</b> 19 @ <b>5:15 A.M.</b> and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b> M.D.				22b. DATE SIGNED <b>3/14/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>				22e. REC'D BY REGISTRAR <b>Arthur L. House</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	
23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2540

## CERTIFICATE OF DEATH

Reg. Dist. No.

02517

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 So. Allegany St.</b>				d. STREET ADDRESS <b>115 So. Allegany St.</b>			
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Morris Leonce Barnes</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Md. Rwy.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Millard Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Mary Belle Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W. W. # 1</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Morris Barnes</b>				Address <b>Cumb. Md. 115 So. Allegany St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atypical Pneumonia</b> DUE TO <b>1 week</b> (c) <b>St. Lung</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2. 23. 1961</b> , to <b>3. 2. 1961</b> , that I last saw the deceased alive on <b>2. 23. 1961</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>3-3-61</b>							
ACTUAL SIGNATURE <b>W. F. Williams</b>				PHYSICIAN'S NAME (Type) <b>W. F. Williams M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal Church Yard.</b>	
22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Fries</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02518

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>165 W. Main Street</b>		d. STREET ADDRESS <b>165 W. Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>A.</b> Last <b>Bauer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8th, 1898</b>
9. AGE (In years lost birthday) <b>62</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Bauer</b>		14. MOTHER'S MAIDEN NAME <b>Christina Meyers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-12-8035</b>	
17. INFORMANT <b>Joseph Bauer, 165 W. Main St., F'bg., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aneurysm of descending aorta</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 mo</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB 13 1961</b> , to <b>MAY 13 1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 12 1961</b> , and that death occurred at <b>5:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. O. McLane</b>		22b. DATE SIGNED <b>MAY 14 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane</b>		22d. ADDRESS <b>167 E. Main St, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph V. R. R. R.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 16 '61</b>	
ADDRESS <b>Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. R. R.</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2542

CERTIFICATE OF DEATH

02519

Item 9 Film 6282 3-14-61 et

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLERSLIE</b> <del>RURAL X CUMBERLAND</del>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>R.</b> Last <b>BENNETT</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 61</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 10-83</b>		9. AGE (In years last birthday) <b>77 7/8</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM L. LOWERY (DEC.)</b>				14. MOTHER'S MAIDEN NAME <b>EMMA LOU LOWERY (DEC.)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerosis - generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial Intestinal Obstruction</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1960</b> to <b>March 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1961</b> , and that death occurred at <b>12:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William P. James, MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES, MD.</b>				22d. ADDRESS <b>4414 Center St. Cumberland Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>March 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Palo Alto Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hyndman Pa. Pa. 1701</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey L. Ziegler, Hyndman, Pa.</b>				25a. REC'D BY REGISTRAR <b>MAR 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. James</b>	

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CERTIFICATE OF DEATH

08219

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Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2543 CERTIFICATE OF DEATH 02520											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. LENGTH OF STAY IN 1b <b>5 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE 2, FLINTSTONE</b>					
d. STREET ADDRESS <b>1</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>GUSTAVA</b> Middle <b>BENNETT</b> Last <b>BENNETT</b>						4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>19 61</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-12-1889</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>						12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>JOHN KAETTERMAN</b>						14. MOTHER'S MAIDEN NAME <b>RUTH DOLLY Mallow</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>710.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Memorials Polycystic</b> <b>Interadema - Renal cyst</b> } (c) INTERVAL BETWEEN ONSET AND DEATH <b>2-12 month</b> <b>year.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>10:36 P.M.</b> <b>March 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 8, 1961</b> , and that death occurred at <b>10:36 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b>						22b. DATE SIGNED <b>3/11/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>						22d. ADDRESS <b>133 VIRGINIA AVENUE-CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>3/11/61</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Glendale Brethren Cem.</b>						23d. LOCATION (City, town or county) (State) <b>Flintstone, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>						25a. REC'D BY REGISTRAR <b>MAR 15 61</b>					
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hafer</b>					

3243

3243

ALLEGANY

WYOMING

ALLEGANY

ROUTE 2, CLINTON

7 DAYS

CLINTON

MEMORIAL HOSPITAL & WARDEN AVENUE

MEMORIAL HOSPITAL

GUSTAVA

BENNETT

MARCH

1-12-1899

WHITE

FEMALE

U. S. A.

WEST VIRGINIA

ROUTE 2, CLINTON

JOHN KATHLEEN

MEMORIAL HOSPITAL - CLINTON, MO.

JOHN

JOHN

10-1-1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2544											
CERTIFICATE OF DEATH											
02521											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT. #1, CUMBERLAND</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>ROSCOE</b> Middle <b>BENNETT</b> Last 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF DEATH <b>MARCH 21 1961</b> 9. AGE (In years last birthday) <b>52</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.						4. DATE OF DEATH <b>MARCH 21 1961</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire builder- Kelly Springfield Tire Co.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>CIRCLEVILLE, W. VA.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>						13. FATHER'S NAME <b>WILLIE BENNETT</b> 14. MOTHER'S MAIDEN NAME <b>ZULA WEIMER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>						16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> 17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> <b>Breast Disease (Chr. Neoplasm)</b> Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (a), stating the underlying cause last. (c) <b>DUE TO</b>						INTERVAL BETWEEN ONSET AND DEATH <b>—</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial &amp; Coronary Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>—</b> p.m. <b>—</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland City Md</b> (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>3/21/61</b> to <b>3/21/61</b> , 19 <b>61</b> , that (I) <b>was</b> last saw the deceased alive on <b>3/21/61</b> , 19 <b>61</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.						22a. SIGNATURE <b>Dr. R. J. Williams</b> 22b. PHYSICIAN'S NAME (Type or print) <b>DR. R. J. WILLIAMS</b> 22c. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3-24-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b> 23d. LOCATION (City, town or county) <b>Cumberland, Maryland</b> (State)						24. FUNERAL DIRECTOR'S SIGNATURE <b>HAFER FUNERAL SERVICE</b> <b>Cumberland, Md.</b> 25a. REC'D BY REGISTRAR <b>MAR 27 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>					

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188 2. CENTRE ST. CUMBERLAND, MD.

OF R. J. WILLIAMS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
DR. B. SCHINDLER 2545 CERTIFICATE OF DEATH 02522

PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>107 BLAUL AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MINNIE B. BLACKER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 15, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>SHARPSBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REUBEN BOWERS</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE GRAY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Hemiplegia</b> DUE TO (b) <b>Myocardial C.V. Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/6/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/4/61</b> , 19 <b>61</b> , and that death occurred at <b>12:55 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>B. M. Schindler</b> 22c. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>		22b. DATE SIGNED <b>3/6/61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>43 Greene Street Cumberland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 6, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 8 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

022528

2525

DR. B. SCHMIDT

ALLEGANY

WYOMING

ALLEGANY

CUMBERLAND

1 DAY

CUMBERLAND

107 BLAU AVENUE

MEMORIAL HOSPITAL

(1)

MARCH

BLANCH

B.

MINUTE

30

MARCH 17, 1969

X

WHITE

REMI

U.S.A.

SHARPSBURG, MARYLAND

OWN HOME

HOUSEWIFE

CAROLINE GRAY

RECTOR BONES

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

NONE

NO

*Handwritten signatures and notes, including "James P. Schmitt" and "Dr. B. Schmidt".*

11/1 12:00 A.M. +

3/14/69

*Handwritten notes and signatures at the bottom left.*

*Handwritten signature "Dr. B. Schmidt" and other notes.*

Burial March 6, 1961 Davis Memorial Park Cumberland, Md.

James P. Schmitt, Cumberland, Md. MAR 8 69

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

DR. TOLSON

## CERTIFICATE OF DEATH

02523

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG,</b> d. STREET ADDRESS <b>184 ORMOND STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WESLEY</b> Last <b>BLOCHER</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>19 61</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-1883</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ISSAC BLOCHER</b>			14. MOTHER'S MAIDEN NAME <b>SOPHIA ANDERSON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>213-10-5273A</b>		
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND MD.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion - sudden</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary sclerosis</b> (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Carcinoma prostate</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> , that (I) (we) last saw the deceased alive on <b>6:30 A.M.</b> , 19 <b>1961</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Howard L. Tolson</b> M.D.			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>DR. HOWARD L. TOLSON</b>			22d. ADDRESS <b>CUMBERLAND, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-13-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JOHNSON CEMETERY</b>	
23d. LOCATION (City, town or county) <b>GARRETT COUNTY</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Trust</b>			25a. REC'D BY REGISTRAR <b>DATE MAR 14 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Trust</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

08253

2515

MR. TOLSON

ALLEGANY

MARYLAND

ALLEGANY

11

FROSTBURG

7 DAYS

CUMBERLAND

181 GORMAN STREET

MEMORIAL HOSPITAL

11

MARCH

1933

1933

JOHN

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11

10-10-1933

WHITE

MALE

U.S.A.

GARRETT CO., MARYLAND

STATE MINES

REGISTERED MINER

SOPHIA ANDERSON

ISSAC BLOOMER

MEMORIAL HOSPITAL - CUMBERLAND, MD.

210-10-1933

*Isaac Bloomer - son of Sophia Anderson*

*Isaac Bloomer*

6:30 A.M.

*Isaac Bloomer*

CUMBERLAND, MD.

DR. HOWARD L. TOLSON

GARRETT COUNTY

JOHNSON GARRETT

3-11-1931

BURIAL

CUMBERLAND

MARYLAND

FROSTBURG, MD.

2547

2547

CERTIFICATE OF DEATH

02524

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>3 HOURS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b> d. STREET ADDRESS <b>Knapps Meadow</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DORA</b> Middle <b>BOORE</b> Last <b>BOORE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>3</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 13, 1909</b>	
9. AGE (In years last birthday) <b>51</b>		IF UNDER 1 YEAR Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>		IF UNDER 24 HRS. Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>TILDEN BOORE (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA PERRIN (DECEASED)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>PATIENT'S CHART</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute heart failure</b> 424.0 DUE TO <b>thyrotoxic heart disease +</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>hypophosphatosis, cor pulmonale</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 years</b> <b>45 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>19 51</b> to <b>3/3</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/3</b> 19 <b>61</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Elizabeth Brings</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>ELIZABETH BRINGS, M.D.</b>				22d. ADDRESS <b>55 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/6/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Mt. Savage, MD.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				ADDRESS <b>LONA CONING, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2548  
CERTIFICATE OF DEATH

02525

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Beall Street</b>				d. STREET ADDRESS <b>5 Beall Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Brain</b> Last <b>Brain</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12th</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19th, 1862</b>	
9. AGE (In years lost birthday) <b>98</b> yrs.		IF UNDER 1 YEAR Months <b>98</b> Days <b>98</b> Hours <b>98</b> Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Enos Brain</b>				14. MOTHER'S MAIDEN NAME <b>Emma Fields</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Earl F. Brain, American Ave., F'bg., Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c) <b>Senility</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1, 1960</b> to <b>MAR 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>MAR 1, 1961</b> , and that death occurred at <b>7:04 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. O. McLane</b>				22b. DATE SIGNED <b>MAR 14 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>				22d. ADDRESS <b>167 E. Main Street, Frostburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>	
23d. LOCATION (City, town, or county) <b>Frostburg,</b>				23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Dunst</b>				24a. ADDRESS <b>Frostburg, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>							

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2549 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Westernport</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>R.D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Donald</b> First <b>Frederick</b> Middle <b>Braithwaite</b> Last				4. DATE OF DEATH <b>Mar.</b> Month <b>6</b> Day <b>19</b> Year <b>61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 4, 1946</b>	
9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Arthur Braithwaite</b>				14. MOTHER'S MAIDEN NAME <b>Alma L. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Arthur Braithwaite-R.D.1 Westernport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <b>LOBAR PNEUMONIA, RIGHT</b></p> <p>(c)</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b></p> <p><b>10 Days</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE OF LEFT HUMERUS: FRACTURE LEFT TIBIA AND FIBULA</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>RAN INTO STOPPED CAR WITH SLED WHILE SLEDRIDING</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:00 a.m. JAN. 22 1961</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET</b>		20f. (City or town) (County) (State) <b>WESTERNPORT, ALLEGANY, MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 6, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Duckworth</b>		22d. LOCATION (City, town, or county) (State) <b>R.D. Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E.S. Bral Westernport, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02527

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>63 FROST AVENUE</b>				d. STREET ADDRESS <b>63 FROST AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESLIE</b> Middle Last <b>BRODE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 8, 1904</b>	
9. AGE (In years lost birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOKKEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PAINT CONTRACTOR</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>GEORGE BRODE</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH HILL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-07-1562</b>		17. INFORMANT Address <b>MRS. PHYLLIS BRODE, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>43444</b> DUE TO (b) <b>Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>1 yr</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1960</b> to <b>March 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>3/3</b> 19 <b>61</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis,</b>				22b. DATE SIGNED <b>3/6/61</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>	
22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <b>3/6/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-6-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durrst</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraye</b>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE OF DECEASED: [REDACTED]  
SIGNATURE OF WITNESSES: [REDACTED]  
SIGNATURE OF PHYSICIAN: [REDACTED]  
SIGNATURE OF CLERK: [REDACTED]



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2551 CERTIFICATE OF DEATH 02528											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>13 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRESAPTOWN</b> d. STREET ADDRESS <b>10 Wood Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>CARRIE Jeanetta CHILCOTT</b>						4. DATE OF DEATH <b>MARCH 18 1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 25, 1876</b>		9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CRESAPTOWN, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN GRANT</b>						14. MOTHER'S MAIDEN NAME <b>MARY MC KENZIE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL,</b> Address <b>CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.0</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 wks</b> <b>3 wks</b> <b>15 yrs</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> , 19 <b>61</b> , to <b>3/18</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> , 19 <b>61</b> , and that death occurred <b>3:12 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Samuel G. Weisman</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>3/20/61</b> 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL G. WEISMAN</b>						22d. ADDRESS <b>59 GREENE ST., CUMBERLAND, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/21/61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>						25a. REC'D BY REGISTRAR <b>MAR 22 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Charles L. Hines</b>		

M

ALLEGANY

HARRISBURG

ALLEGANY

CUMBERLAND

13 DAYS

CUMBERLAND

MEMORIAL HOSPITAL  
MEMORIAL & MARSHALL STS.

10 Wood Street

CARRIE

Umbagog

CHILCOTT

MARCH

18

61

WHITE

DEC. 25, 1922

U.S.A.

CUMBERLAND, MD.

W. H. HARRIS

JOHN GRANT

MARY MC KEITZ

100

MEMORIAL HOSPITAL,

CUMBERLAND, MD.

15:15 AM

SAMUEL A. WEISMAN

39 GROVE ST., CUMBERLAND, MARYLAND

1924

3/1/24

Ellington Street, York

Cumbersburg, Maryland

John T. Harter, Cumbersburg, Maryland

Mar 25, 1924

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

09/

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2552

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02529

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>3/8/1958</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Unger</b> Last <b>Cline</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/1879</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Alfred Cline</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Dudley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocardial Degeneration</b> DUE TO (c) <b>Senile Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/8/58</b> 19 to <b>3/22/61</b> 19, that (I) (we) last saw the deceased alive on <b>3/22/61</b> 19 @ <b>10:50 P.M.</b> , and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James E. McLean</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		23d. LOCATION (City, town, or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montecant</b>				25a. REC'D BY REGISTRAR <b>23 E. Main, Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b>	

07/

James H. Brewster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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2553  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02530

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN lb <b>3/2/61</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Cecilia</b> Last <b>Coleman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>P.O.Box 599</b>	
17. INFORMANT <b>Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> 422.2 DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Chronic osteo-arthritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/2/61</b> 19 to <b>3/12/61</b> 19, that (I) (we) last saw the deceased alive on <b>3/11/61</b> 19, and that death occurred at <b>7:50 A.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b> M.D.		22b. DATE SIGNED <b>3/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR <b>Lonaconing, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE MAR 15 '61</b>		25c. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

CERTIFICATE OF DEATH

3553

Allegany

West Virginia

Allegany

Midland

3/2/51

Superior

Allegany County, West Virginia

13, 1951

Johnnie B. Baker

Female

White

10

10/1/51

X

White

Housewife

Lawrence, Maryland

John Cunningham

West Virginia

Allegany County, West Virginia

3/2/51

Dr. James E. Baker

Dr. James E. Baker

Allegany County, West Virginia

Allegany County, West Virginia



may be obtained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2554

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02531

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Colmer</b> Last <b>Colmer</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1897</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Avilton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Edward Weimer</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Chaney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Gilbert Colmer</b> Address <b>Nikep, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>"Husband" Acute massive myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>① DIABETES ② Pneumonia?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>X</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>				20f. (City or town) (County) (State) <b>X</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>61</b> , to <b>3/29</b> , 19 <b>61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>3/29</b> , 19 <b>61</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Martin M. Rothstein M.D.</b>				22b. DATE SIGNED <b>3/30/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D.</b>				22d. ADDRESS <b>48 BROADWAY - FROSTBURG - MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Ann Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Avilton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>			
ADDRESS <b>Lonaconing, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 16, 22d Film C282 3/9/61

Reg. Dist. No.

02532

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New Jersey</b> b. COUNTY <b>Essex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>16 Min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>C.</b> Last <b>CONNOR</b>		4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/1891</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bell Tel. Co., N.J.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hope Twp., N. Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Wyman Connor</b>		14. MOTHER'S MAIDEN NAME <b>Florence Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW <b>1</b>		16. SOCIAL SECURITY NO. <b>137-01-9522</b>	
17. INFORMANT <b>Mrs. Clyde D. Connor, Verona, N.J.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10-20 Min.</b> -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>March 4, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Verona, N.J. Sparkill, N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02533

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>65 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>434 Broadway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>LOUISE</b> Last <b>COTTOM</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1874</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Buffalo Mills, Pa.</b>	
13. FATHER'S NAME <b>Franklin P. Elder</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Shoemaker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Allen Steiner, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis &amp; Decompensation</b> DUE TO <b>2 yrs</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>Mar 18, 1961</b> that (I) (we) last saw the deceased alive on <b>Mar 12, 1961</b> and that death occurred at <b>7:15, P.M.</b> the causes and on the date stated above.							
22a. SIGNATURE <b>Clay E. Durett</b>				22b. DATE SIGNED <b>3/20/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Clay E. Durett, M.D.</b>	
22d. ADDRESS <b>Va. Ave., Cumberland, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>				25a. RECEIVED BY REGISTRAR DATE <b>MAR 22 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

(M)

2255

CERTIFICATE OF DEATH

2255

State of New York  
County of New York  
City of New York  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 12th day of March, 1914, at New York City, New York, I attended the body of  
John J. Jones, deceased, who was born on the 15th day of January, 1870, at New York City, New York, and who died of  
Heart Disease, and I am satisfied that the same was the result of natural causes.  
Witness my hand and the seal of my office this 12th day of March, 1914.  
J. J. Jones, M.D.  
Physician



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2557

## CERTIFICATE OF DEATH

02534

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MILFORD</b> Middle <b>Frederick</b> Last <b>DREYER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 24, 1888</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.CO.</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>CHARLES DREYER</b>			
14. MOTHER'S MAIDEN NAME <b>MARY KRAPE</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Arteriosclerosis</b> (e), stating the underlying cause last. DUE TO (c) <b>you</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/15/61</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>3/17</b> , 19 <b>61</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. GEORGE SIMONS</b>				22b. DATE SIGNED <b>3/20/61</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. GEORGE SIMONS</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



ALLIANCE

CUMBERLAND

MEMORIAL HOSPITAL

MILFORD

WHITE

RETIRED

CHARLES GREYER

12 DAYS

B. A. O. R. CO.

MARYLAND

CUMBERLAND

807 COLUMBIA AVENUE

CHARLES GREYER

APRIL 24, 1933

CUMBERLAND, MARYLAND

MARY KARP

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

CUMBERLAND, MARYLAND

John J. Harter, Cumberland, Md.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2558

02535

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 1, Frostburg</b>				c. LENGTH OF STAY IN 1b <b>60Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lizzie</b> Middle <b>B.</b> Last <b>Duckworth</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17th</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 21st, 1876</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>David Robinette</b>				14. MOTHER'S MAIDEN NAME <b>Claranda Twigg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Charles Dayton, Rt. 1, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Semility</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> 19 <b>60</b> to <b>Mar 17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Mar 9</b> 19 <b>61</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W O McLane</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar 18 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane</b>				22d. ADDRESS <b>167 E. Main St., Frostburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loar Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rt. 1, Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Hurst</b>				ADDRESS <b>Frostburg, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 21 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

3558

Alfred ...  
St. J. ...  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2559

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 02536

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">Allegany</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.5em;">West Virginia</span> b. COUNTY <span style="font-size: 1.5em;">Mineral</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.5em;">Frostburg</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.5em;">4 months</span>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.5em;">Keyser</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.5em;">144 Maple Street</span>				d. STREET ADDRESS <span style="font-size: 1.5em;">Star Route</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)				<b>4. DATE OF DEATH</b>			
First <span style="font-size: 1.5em;">Laura</span> Middle <span style="font-size: 1.5em;">Tressie</span> Last <span style="font-size: 1.5em;">Fike</span>				Month <span style="font-size: 1.5em;">March</span> Day <span style="font-size: 1.5em;">27</span> Year <span style="font-size: 1.5em;">1961.</span>			
5. SEX <span style="font-size: 1.5em;">Female</span>	6. COLOR OR RACE <span style="font-size: 1.5em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">June 18, 1877</span>		9. AGE (In years last birthday) <span style="font-size: 1.5em;">83</span> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Housewife</span>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Terra Alta, West Virginia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U. S. A.</span>
13. FATHER'S NAME <span style="font-size: 1.5em;">James S. Myers</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Maria Sypolt</span>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		<b>INFORMANT</b> Address <span style="font-size: 1.5em;">Mrs. Maria McFarland, Frostburg, Maryland.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Carcinomatosis, primary in stomach.</span>							<span style="font-size: 1.5em;">6 mos.</span>
DUE TO (b) <span style="font-size: 1.5em;">Metastasis to brain, liver,</span>							
DUE TO (c) <span style="font-size: 1.5em;">local and regional nodes.</span>							<span style="font-size: 1.5em;">3 mo.</span>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <span style="font-size: 1.5em;">Jan. 31,</span> 19 <span style="font-size: 1.5em;">61</span> to <span style="font-size: 1.5em;">March 27,</span> 19 <span style="font-size: 1.5em;">61</span> that I last saw the deceased alive on <span style="font-size: 1.5em;">19</span> , and that death occurred at <span style="font-size: 1.5em;">12 Noon</span> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <span style="font-size: 1.5em;">Alvin J. Walters</span> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <span style="font-size: 1.5em;">48 Broadway, Frostburg, Md. 3/29/61</span>			
PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">ALVIN J. WALTERS</span> M.D.				<span style="font-size: 1.5em;">Frostburg, Maryland.</span>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<span style="font-size: 1.5em;">Removal &amp; Burial</span>		<span style="font-size: 1.5em;">3-30-61</span>		<span style="font-size: 1.5em;">Gortner Union Cemetery</span>		<span style="font-size: 1.5em;">Gortner, Maryland.</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.5em;">Terra Alta, W. Va.</span>				ADDRESS <span style="font-size: 1.5em;">Md. F.D. License No. A8305</span>		24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.5em;">APR 3 '61</span>	
				24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.5em;">Gordon S. Kline</span>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

Metastasis to brain, liver,

local and regional nodes. 3 m.

W. J. W. W.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2560

Item 9 Film G283 3/23/61

02537

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG, RT. 1,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL JAMES FILER</b>		4. DATE OF DEATH Month Day Year <b>MARCH 16 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 11, 1921</b>
9. AGE (In years lost birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEAM FIREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TEACHERS COLLEGE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL FILER</b>		14. MOTHER'S MAIDEN NAME <b>NANNIE FATKIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-18-2152</b>	
17. INFORMANT <b>MRS. SAMUEL FILER, FROSTBURG, MD. RT. 1,</b>		Address <b>BOX 88</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dilatation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac congestive Failure + Pulmonary edema</b> DUE TO (c) <b>Emphysema with fibrosis (pulmonary)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cor pulmonale: Chronic Cholecystitis + cholelithiasis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>6 days</b> <b>+ 10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/20 1951</b> , to <b>3/16 1961</b> , that (I) <del>(we)</del> lost the deceased on <b>3/16 1961</b> , and that death occurred at <b>9:35</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank T. Harrat</b> 22c. PHYSICIAN'S NAME (Type) <b>F. T. HARRAT, M. D.</b>		22b. DATE <b>3/17/61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>26 W. MECHANIC ST., FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-18-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Hurst</b> ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton S. Harrat</b>			

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may be obtained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

2561

**CERTIFICATE OF DEATH**

02538

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
c. LENGTH OF STAY IN 1b <b>15 days</b>				d. STREET ADDRESS <b>112 N. Smallwood Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WALTER</b> Last <b>FISHER</b>				4. DATE OF DEATH Month <b>3</b> Day <b>17</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/28/81</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Dep. Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Allegany Circuit Court</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN F. FISHER</b>			
14. MOTHER'S MAIDEN NAME <b>MARY Koegel</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>			
16. SOCIAL SECURITY NO. <b>213-12-9674</b>				17. INFORMANT <b>Miss Lois V. Fisher</b> Address <b>Cumb. Md. 112 N. Smallwood St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Renal Disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> 19 <b>61</b> to <b>3/17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> 19 <b>61</b> , and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo H. Ley, Jr.</b>				22b. DATE SIGNED <b>3/17/61</b>		22c. PHYSICIAN'S NAME (Type) <b>LEO H. LEY, M.D.</b>	
22d. ADDRESS <b>456 N. CENTER STREET</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2562

02539

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>				e. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>JOHN</b> Last <b>GETSON</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 29, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>			
13. FATHER'S NAME <b>? Henry John Getson</b>				14. MOTHER'S MAIDEN NAME <b>Anne Petenbrink</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-14-6168</b>			
17. INFORMANT <b>SON* EARL GETSON</b>				Address <b>CORRIGANVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of liver</b> DUE TO <b>153.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma colon</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>60</b> to <b>March</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3-18</b> 19 <b>61</b> , and that death occurred at <b>4:55 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William P. James</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. W.P. James, M.D.</b>				22d. ADDRESS <b>4141 N. Centre St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Garden, Cumberland, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Seigler</b>				ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02540

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CRESAPTOWN</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>VIOLA</b> Last <b>GRANT</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 18, 1914</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE Post Mistress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US Post Office</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JERRY TAYLOR (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE HUFF</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>PATIENTS CHART</b>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Surgical shock</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>abdominal perineal resection</b> DUE TO (c) <b>concomitant of the resection</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> 19 <b>61</b> , to <b>3-16</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3-16-1961</b> , and that death occurred <b>12:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L Brings</b>				22b. DATE SIGNED <b>3/17/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lewis Brings, M.D.</b>				22d. ADDRESS <b>57 Green St.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/19/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Bier Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Rawlings, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2564 Item 8 Film G204 4/6/61 lwk  
CERTIFICATE OF DEATH

02541

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1 Rt. #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELMER</b>		4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>19 61</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/17/1919 1918</b>	
9. AGE (In years last birthday) <b>42</b> YES <input type="checkbox"/>		10. UNDER 1 YEAR Months <b>3</b> Days <b>31</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd jobs</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Midlothian</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Harris</b>		14. MOTHER'S MAIDEN NAME <b>Alice Hayes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Arthur Harris</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra caranial Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Metastatic Carcinoma</b> (c) <b>Carcinoma of Right Testic</b> 178X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus, Asthma.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>unk.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 27, 1961</b> to <b>March 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 30, 1961</b> , and that death occurred <b>3:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Alvin J. Walters</b>		22b. DATE SIGNED <b>April, 2, '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alvin J. Walters M.D.</b>		22d. ADDRESS <b>48 Broadway, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/2/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Percy Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bulah H. Montanant</b>		25a. REC'D BY REGISTRAR <b>APR 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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Timothy H. McIntyre

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2565

## CERTIFICATE OF DEATH

Reg. Dist. No.

02542

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>128 POLK STREET</u>		d. STREET ADDRESS <u>128 POLK STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>WILLIAM</u> <u>HERING</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>21</u> , <u>19</u> <u>61</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 26, 1889</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		9b. AGE (In years last birthday) yrs. <u>71</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING &amp; HEATING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>FREDERICK HERING</u>		14. MOTHER'S MAIDEN NAME <u>CLARA OGLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW 1 214 07 1256</u>	
17. INFORMANT <u>HELEN V. HERING</u>		Address <u>CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>March 21, 1961</u> , that I last saw the deceased alive on <u>March 11</u> , 19 <u>61</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard W. Truaskis, Jr.</u>		M.D. <u>Cumberland, Maryland</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/24/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CUMBERLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u>		ADDRESS <u>CUMBERLAND, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2566  
CERTIFICATE OF DEATH  
02548

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CORDELIA</b> Middle <b>Mildred</b> Last <b>HOLLY</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 23, 1903</b>	
9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Theater</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FROSTBURG, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>FRANK MARSHALL</b>				14. MOTHER'S MAIDEN NAME <b>MARY JONES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-22-3403</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b> DUE TO (b) <b>Myocardial Degeneration</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <b>Hypertensive Cardio-Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> to <b>3/11</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/11</b> , 19 <b>61</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo H. Ley, Jr.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO H. LEY, JR.</b>				22d. ADDRESS <b>456 NORTH CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/14/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

05553

2566



ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

15 DAYS

CUMBERLAND

GENERAL & WARREN AVES.

250 EIGHTH STREET

GENERAL HOSPITAL

11 0 61

MARCH

HOLLY

WINTER

CORDELLA

NOVEMBER 23, 1902

FEMALE COLORED

U. S. A.

FROSTBURG, MARYLAND

MARY JONES

WASH. HOSPITAL

GENERAL HOSPITAL - CUMBERLAND, MD.

2:00 P.M.

155 NORTH CENTRAL ST., CUMBERLAND, MD.

DR. LEO H. LEY, JR.

John W. Nelson, Cumberland, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02544**

**2567**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Oldtown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rt. # 1 Oldtown,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bear Hill Road</b>				d. STREET ADDRESS <b>/ Bear Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Isabelle</b> Last <b>Hong</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Wilbert Appold</b>				14. MOTHER'S MAIDEN NAME <b>Laura Garrett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Richard Page Newport News, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>-----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PORTAL CIRRHOSIS: CHRONIC NEPHRITIS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>MARCH 10, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Oldtown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2020

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2568 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02545

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN lb <u>50 Min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route #1, Flintstone</u> d. STREET ADDRESS <u>Flintstone</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CALVIN</u> Middle <u>JUDY</u> Last <u>HUFFMAN</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>8</u> Year <u>19 61</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 12, 1886</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self Employed</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Onego, W. Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>David Huffman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Dorothy Kisamore</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. C.J. Huffman, Rt. #1, Flintstone, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertensive Cardiovascular Disease. ?</u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarellic</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>3/9/61</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarellic, M.D.</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>							
<b>22b. DATE THEREOF</b> <u>3/11/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Huffman Family Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Near Flintstone, Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hafer, Cumberland, Maryland</u>						<b>24a. REC'D BY REGISTRAR</b> <u>MAR 15 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2569

CERTIFICATE OF DEATH

02546

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAYME</b> Middle <b>JENSEN</b> Last <b>JENSEN</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 8, 1902</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Hyndman, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James M. Holler</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Steckman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Walter Jensen Corrigansville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive and arterio-</b> (c) <b>sclerotic cardiovascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous Coronary 1949</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>9:15 a.m. 3/22/61</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hyndman, Pa.</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-5-61</b> 19 <b>61</b> to <b>3-22</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3-7</b> 19 <b>61</b> , and that death occurred at <b>9:15 AM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas Lushy</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>T.F. LUSHY</b>				22d. ADDRESS <b>125 Bedford St Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey S. Leigler</b>				ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2570

CERTIFICATE OF DEATH

02547

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt #1 Cumberland</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Rt #1 Cumberland, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>Homewood Addition</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>Mae</b> Last <b>JEWELL</b>				4. DATE OF DEATH Month <b>3</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/18/82</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10. AGE UNDER 1 YEAR Months <b>3</b> Days <b>21</b> Hours <b>1961</b>		11. AGE UNDER 24 HRS. Months <b>3</b> Days <b>21</b> Hours <b>1961</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>THOMAS Cline</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA SPITZER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Charles E. Jewell</b> Address <b>Rt. # 1 Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure &amp; Pneumonitis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Accident, acute, with left hemiplegia and swallowing difficulty</b> DUE TO (c) <b>Arteriosclerotic &amp; Hypertensive Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>36 hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>August 19 58</b> to <b>March 21, 19 61</b> that (I) (we) last saw the deceased alive on <b>March 21, 19 61</b> , and that death occurred at <b>7:20 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Wyand F. Doerner</i>				22b. DATE SIGNED <b>3-23-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>WYAND F. DOERNER M.D.</b>				22d. ADDRESS <b>ALGONQUIN BLDG. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>							

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

1910

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2571

Item 8 Film 0282 3/9/61 mh

02548

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>		d. STREET ADDRESS <b>503 FURNACE STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES H. JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>MARCH 1, 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-26-1877 1876</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Sexton</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY DHNSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>2 19-30-9976</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerbtic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>uremia BPH</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>3.1.61</b> , that (I) (we) last saw the deceased alive on <b>2.28.61</b> 19, and that death occurred on <b>3.1.61</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. P. James</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3.1.61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. W.P. JAMES, M.D.</b> 22d. ADDRESS <b>441 N. Centre St, Cumberland, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/5/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 3 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

02548

CERTIFICATE OF DEATH

2271

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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CAUSE OF DEATH

AGE AT DEATH

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PLACE OF BIRTH

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PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

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DATE OF BIRTH

PLACE OF BIRTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2572  
CERTIFICATE OF DEATH

02549

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
c. LENGTH OF STAY IN 1b <b>25 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>126 WOOD ST.</b>		d. STREET ADDRESS <b>126 WOOD ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>JONES</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 11, 1876</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN JONES</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>MRS. WALTER LA RUE, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Cardiac Failure</b> DUE TO (b) <b>Arteriosclerotic C-V disease ± 10 yrs</b> DUE TO (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>8/30</b> 19 <b>60</b> , to <b>3/7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> 19 <b>61</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank T. Harrat</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. T. HARRAT, M. D.</b>		22d. ADDRESS <b>26 W. MECHANIC ST., FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-9-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>GARRETT COUNTY</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Harrat</b> ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 9 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harrat</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2573 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02550

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>48 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>411 Decatur Street</u>				d. STREET ADDRESS <u>411 Decatur Street</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Izora Isabelle Jones</u>				4. DATE OF DEATH Month Day Year <u>March 25 19 61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12, 1867</u>			
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Jacob Ziler</u>				14. MOTHER'S MAIDEN NAME <u>Mary McCulley</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Earl E. Jones</u> <u>217 Fulton Street, Cumberland, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>**---</u>								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 25, 1961</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> <u>Cumberland Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Koons</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2574

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02551

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural near <del>Allegany</del> Cumberland</u>				c. LENGTH OF STAY IN 1b <u>4 Yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. #4 Oldtown Road</u>				d. STREET ADDRESS <u>8 South Allegany Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SHERMAN</u> First <u>PHILLIP</u> Middle <u>KEEL</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 30, 1890</u>	9. AGE (In years last birthday) <u>70 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Green Ridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Keel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. S.P. Keel, 8 S. Allegany, Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT of Head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>2:00 a.m. MARCH 14 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>MARCH 14, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chaneyville Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chaneyville, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

082521

DATA

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
ADDRESS OF DECEASED [REDACTED]		ADDRESS OF EXAMINER [REDACTED]		ADDRESS OF WITNESS [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	
ZIP CODE [REDACTED]		TELEPHONE [REDACTED]		FAX [REDACTED]	
MEDICAL HISTORY [REDACTED]		PHYSICAL EXAMINATION [REDACTED]		LABORATORY TESTS [REDACTED]	
RADIOLOGICAL EXAMINATIONS [REDACTED]		PATHOLOGICAL FINDINGS [REDACTED]		TOXICOLOGICAL FINDINGS [REDACTED]	
OTHER FINDINGS [REDACTED]		CONCLUSIONS [REDACTED]		RECOMMENDATIONS [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
ADDRESS OF EXAMINER [REDACTED]		ADDRESS OF WITNESS [REDACTED]		ADDRESS OF DECEASED [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	
ZIP CODE [REDACTED]		TELEPHONE [REDACTED]		FAX [REDACTED]	

DATA

DATA





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02552

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Bedford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyndman Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Londonderry Township</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>John A llen</u> <u>KENDALL</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 9, 1961</u> <u>19</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 18, 1914</u>		<b>9. AGE</b> (In years last birthday) <u>46</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Trucker</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Friendsville, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>J. C. Kendall</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Kathryn Mason</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-10-2984</u>		<b>17. INFORMANT</b> Address <u>Mrs. John Kendall, Hyndman, Pa. RD#1</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u>            DUE TO (c)         </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>S UDDEN</u>    <u>**--</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelic</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarelic, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>March 9, 1961</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>March 12, 1961</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Palo Alto Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Hyndman, Pa. RD#1</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harvey J. Zepher</u>				<b>ADDRESS</b> <u>Hyndman, Pa.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAR 13 '61</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Huns</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

00228

MARVINO STATE DEPARTMENT OF HEALTH - BATHING 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2018

Form No. 100

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2576

## CERTIFICATE OF DEATH

02553

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;">b. STATE <b>MARYLAND</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ALLEGANY</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>213 PENNSYLVANIA AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>BERNARD WILLIAM KUHLMAN</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>19</b> Year <b>61</b>		<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>MAY 14, 1900</b>		<b>9. AGE</b> (In years last birthday) <b>60</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CELANESE</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MT. SAVAGE, MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>GEORGE KUHLMAN</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>ADELINE RARRICK</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-10-4403</b>				<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH: <b>immediate</b> <b>immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <b>Healed Ulcer - Healed - Scarred -</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Cumby, Alleg. Md.</b>		(County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2/12/61</b> <b>4:50 A.M.</b> <b>3/19/61</b> , 19____, <b>that (I) (we) last saw the deceased alive on</b> <b>3/18/61</b> , 19____, <b>and that death occurred at</b> <b>4:50 A.M.</b> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>DR. RICHARD J. WILLIAMS</b> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. ADDRESS</b> <b>Cumberland, Md.</b>			<b>22b. DATE SIGNED</b> <b>3/19/61</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>3-21-1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mary's Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>Cumberland, Md.</b> (State) _____			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>MAR 22 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

3 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

313 PENNSYLVANIA AVENUE

BERNARD

WILLIAM KILLMAN

WILLIAM KILLMAN

MARCH 19

1961

WIFE

WHITE

MAY 19, 1930

60

WACHNIST

CHINESE

MT. SAVAGE, MARYLAND

U.S.A.

GEORGE KILLMAN

ADULTIVE RABBIT

no

ELY-TO-AGGS

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

DR. RICHARD J. MILLING

Serial 2-1-1961 St. Mary's Cemetery, Cumberland, Md.

James P. Scott, Cumberland, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02554

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>20 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1138 Braddock Road</b>				d. STREET ADDRESS <b>1138 Braddock Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>RINEHART</b> Last <b>KUYKENDALL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1913</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Reeses Mill, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Elija Kuykendall</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Catherine Fleek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 217-09-7096</b>		17. INFORMANT Address <b>Mrs. R.R. Kuykendall, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 27, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/30/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwell Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reeses Mill, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Colman S. Thomas</b>	



• **ACCS**

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• **STAYING POWER** – The ability to maintain a high level of performance over a long period of time.

THE UNIVERSITY OF CHICAGO

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02555**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>20 Hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS SIDNEY LEAKE</b>		4. DATE OF DEATH Month Day Year <b>March 29 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/1911</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Celanese</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Midland, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>UAa</b>	
13. FATHER'S NAME <b>John Leake</b>		14. MOTHER'S MAIDEN NAME <b>Maude Winters Leake</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-05-5724</b>	
17. INFORMANT <b>Mrs. Jean Steele Leake</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusions of brain, Intracranial Hemorrhage</b> DUE TO (b) <b>Skull Fracture</b> DUE TO (c) <b>(WIFE)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell about 10 feet while at work--Celanese Corp.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:30 a.m. Mar 28 61</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 29, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		24a. REC'D BY REGISTRAR <b>APR 3 '61</b>	
ADDRESS <b>LONACONING, MD.</b>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VR A15 (4)  
15M 9/59

2578

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02557

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>42 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>923 BEDFORD STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUFUS D. NAVE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 24, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY FIREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GOERGE W. NAVE</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA ROLLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-05-5785</b>	
17. INFORMANT <b>MRS. ELIZABETH NAVE, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> 19 p. m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/10/61</b> 19 to <b>3/22/61</b> 19, that (I) (we) last saw the deceased alive on <b>3/20/61</b> 19, and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>3/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/24/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL MAUSOLEUM</b>		23d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2579

02558

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> <span style="float: right;">c. LENGTH OF STAY IN 1b <b>7 DAYS</b></span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ALLEGANY</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>830 GREENE STREET</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>HAZEL H. ODER</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>24</b> Year <b>1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>JULY 12, 1890</b>		<b>9. AGE</b> (In years last birthday) <b>70</b> yrs. <div style="display: flex; justify-content: space-between;"> <span>IF UNDER 1 YEAR</span> <span>IF UNDER 24 HRS.</span> </div>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Bank Ass.</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>KANSAS CITY, MISSOURI</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>ROBERT S. ODER</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA M. HEINTZ</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-14-4028</b>			
<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma left breast.</b> (b) <b>(Metastases to left lung &amp; spine)</b> (c) <b>Since 2/22/55</b>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Radical mastectomy (left) 2/28/55</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2-22-55</u> to <u>3-24-61</u>, 19<u>61</u>, that (I) <del>(we)</del> last saw the deceased alive on <u>3-24-61</u>, 19<u>61</u>, and that death occurred at <u>1:40 PM</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>W. F. Williams</b> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>3/25/61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. W. F. WILLIAMS</b>		<b>22d. ADDRESS</b> <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/27/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Mausoleum</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Cumberland MD.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Louis Stein Inc. Cumb. MD.</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>MAR 27 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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2570



ALLEGANY

HATFIELD

ALLEGANY

CHANDLER

7 DAYS

CHANDLER

MEMORIAL HOSPITAL

MORRIS & MEMORIAL AVENUE

800 DELICIE STREET

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10. 11. 12.

JULY 13, 1900

WHITE

U. S. A.

KANSAS CITY, MISSOURI

MINA M. HENRI

ROBERT S. GOS

I

MEMORIAL HOSPITAL - CHANDLER, MO.

*Robert S. Gos left for St. Louis  
Missouri to get his things (July 13, 1900)*

*Robert S. Gos left for St. Louis  
Missouri to get his things (July 13, 1900)*

*July 13, 1900*

*July 13, 1900*

*July 13, 1900*

155 S. CENTRE ST., CHANDLER, MO.

DE. W. F. WILLIAMS

*Robert S. Gos left for St. Louis  
Missouri to get his things (July 13, 1900)*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02559

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>56 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BEANS COVE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>ODGERS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1874</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Odgers</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Edwards</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Nellie Odgers, RFD Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 10</b> to <b>3-1-1961</b> , that (I) (we) last saw the deceased alive on <b>3-1-1961</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James T. Johnson Jr.</b>		22b. DATE SIGNED <b>3-2-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES T. JOHNSON JR., MD.</b>		22d. ADDRESS <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/4/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prosperity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>RFD Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 6 '61</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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*[Faint, illegible text, possibly bleed-through from the reverse side of the page]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02560**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>LIFE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> <span style="float: right;">02</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>626 COLUMBIA AVE</b>				d. STREET ADDRESS <b>626 COLUMBIA AVE</b> <span style="float: right;">1</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ETHEL</b> Middle <b>G.</b> Last <b>OWINGS</b>				<b>4. DATE OF DEATH</b> Month <b>3</b> Day <b>28</b> Year <b>1961</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JUNE 18, 1896</b>		<b>9. AGE</b> (In years full birthday) <b>64</b> yrs.	<b>IF UNDER 1 YEAR</b> Months      Days	<b>IF UNDER 24 HRS.</b> Hours      Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>	
<b>13. FATHER'S NAME</b> <b>LORENZO VALENTINE</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MATTIE BRANT</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> Address <b>GEORGE R. OWINGS</b> <b>CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>420-1</b> <b>IMMEDIATE CAUSE (a)</b> <b>CORONARY OCCLUSION</b>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b>            DUE TO      (c)         </div> <div style="width: 45%; text-align: right;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>SUDDEN</b>  <b>----</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour      a. m.      p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County)      (State)	
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>BENEDICT SKITARELIC, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>MARCH 11 28, 1961</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>3/31/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>SUNSET MEMORIAL PARK</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>CUMBERLAND, MD.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>BYRON KIGHT</b> <b>CUMBERLAND, MD.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 30 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4250

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2582

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02561

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WILLOWBROOK ROAD</b>				d. STREET ADDRESS <b>WILLOWBROOK ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>J.</b> Last <b>PFEIFFER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 17, 1923</b>	
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months <b>XX</b> Days <b>24</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Months <b>XX</b> Days <b>24</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY GOV'T</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>LAMBERT BLUME</b>				14. MOTHER'S MAIDEN NAME <b>PAULINE BRANT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218 12 5528</b>		17. INFORMANT <b>John H. Pfeiffer</b> Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Breast - left</b> DUE TO <b>Metastatic carcinoma liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>&amp; both ovaries</b> (b) <b>?</b> (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 24, 1961</b> to <b>March 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 24, 1961</b> and that death occurred at <b>PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Royce Hodges</b>				22b. DATE SIGNED <b>March 25, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. Royce Hodges</b>				22d. ADDRESS <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 29 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2583

CERTIFICATE OF DEATH

02562

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b>					
c. LENGTH OF STAY IN lb <b>10 DAYS</b>				d. STREET ADDRESS <b>42 D. STREET</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ADAM W PLUM</b>		First Middle Last		4. DATE OF DEATH <b>MARCH 18 19 61</b>		Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JA. 8, 1895</b>			
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>JOHN PLUM</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Johns</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>705-10-1590</b>					
17. INFORMANT <b>Mrs Bertha M. Plum Keyser WVA</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> DUE TO <b>Advanced.</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>High amputation Rt. leg. 3.15.61. Embolism, multiple, arteries Rt. lower extremity &amp; gangrene</b>								INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3.8.1961</b> to <b>3.18.1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>3.18.1961</b> , and that death occurred <b>1:40 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>W. F. Williams</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/18/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. F. WILLIAMS</b>				22d. ADDRESS <b>Cumberland MD 3-18-61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAR 21, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem. Garden</b>		23d. LOCATION (City, town or county) (State) <b>LAVALL, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. K. Chambers, Keyser, WVA</b>				ADDRESS <b>Keyser, WVA</b>		25a. REC'D BY REGISTRAR <b>MAR 21 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>					



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CHURCHLAND

TO DAYS

KEYSED

REHABILITATION HOSPITAL  
MEMORIAL & WARDEN AVES.

15 D. STREET

ADAM

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MARCH 18

1941

WHITE

MALE

M. B. 1897

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Conductor

B & O R.R.

PLUM

U.S.A.

JOHN PLUM

Margaret Johns

705-10-1280

NO

*Highly important to the life of the community...*

*3-10-41*

*3-10-41*

*W. F. WILLIAMS*

*Black Church, New York City*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

2584

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02563

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>48 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>802 GEPHART DRIVE</u>				d. STREET ADDRESS <u>802 GEPHART DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>RICKEY</u> Last <u>RICKEY</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>19 61</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 8, 1896</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>61</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES BANE</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE BUCKNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ORLAND D. RICKEY</u> <u>CUMBERLAND, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UPPER RESPIRATORY INFECTION</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>MARCH 4, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 7, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST BURIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CUMBERLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u>				ADDRESS <u>CUMBERLAND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knepp</u>	

DATE SIGNED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2585

CERTIFICATE OF DEATH

Item 8 Film 02564 3/17/61 mh

02564

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> d. STREET ADDRESS <b>Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>K. Robertson</b> Last 4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1961</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 12, 1891</b> 9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, Maryland</b> 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Andrew Morton</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Mrs. Margaret Stakem Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 331X DUE TO <b>Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis - Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>2 weeks</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 4, 1961</b> to <b>March 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1961</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L.R. Miles, Jr.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3/13/61</b>		22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b> 22d. ADDRESS <b>LONACONING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/15/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b> 23d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 15 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>	

MEDICAL CERTIFICATION

MAINTENANCE AND STATE DEPARTMENT OF HEALTH

20251



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2586

02565

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>614 Baltimore Avenue</b>				d. STREET ADDRESS <b>614 Baltimore Avenue</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>RUDOLPH</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25, 1888</b>			
9. AGE (In years lost birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Meat Dealer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Butcher Shop</b>					
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Conrad Rudolph</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Ruehl</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.					
17. INFORMANT <b>Paul Rudolph, Cumberland, Md.</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 y.</b> <b>2 y.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Transverse Colon</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>July 19 60</b> to <b>April 30 19 61</b> , that (I) (we) last saw the deceased alive on <b>March 28 19 61</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>S. G. Weisman</b>				22b. DATE SIGNED <b>4/1/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>S. G. Weisman, M.D.</b>				22d. ADDRESS <b>59 Greene Street, Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 2, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>4/3/61</b>					
				25b. REGISTRAR'S SIGNATURE <b>C. B. K...</b>					

0250

CERTIFICATE OF DEATH		DECEASED		REPORTING OFFICER	
NAME	AGE	SEX	RACE	RESIDENCE	DATE OF DEATH
John J. Smith	45	Male	White	123 Main St., New York, N.Y.	Jan. 15, 1928
Cause of Death: Heart Disease					
Place of Death: Home					
Signature of Reporting Officer: [Signature]					
Signature of Medical Officer: [Signature]					
Signature of Coroner: [Signature]					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2537

CERTIFICATE OF DEATH

Reg. Dist. No. 02566

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCoole</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCoole</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home 4 Queen St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>Belle</b> Last <b>Sample</b>				4. DATE OF DEATH Month <b>March.</b> Day <b>19,</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 18, 1894</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. UNDER 1 YEAR Months <b>2</b> Days <b>1</b>		11. UNDER 24 HRS. Hours <b></b> Min. <b></b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dawson, Maryland</b>	
13. FATHER'S NAME <b>John Ravenscroft</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Ravenscroft</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>			
INFORMANT				Address <b>C.L. Robinson, 735 N. Main St. McCoole, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1 Ventricular Fibrillation</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Several years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1/9</b> , 1960, to <b>3/19</b> , 1961, that I last saw the deceased alive on <b>2/9/61</b> , and that death occurred on <b>12:35 P.M.</b> on the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Keyser, W. Va.</b> DATE SIGNED <b>3-20-61</b>							
ACTUAL SIGNATURE <b>Phillip G. Staggers, M.D.</b>				M.D. <b>Keyser, W. Va.</b>			
PHYSICIAN'S NAME (Type) <b>Phillip G. Staggers</b>				M.D. <b>Keyser, W. Va.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-22-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Queen's Point Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Keyser, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Smith</b>				ADDRESS <b>Keyser, W. Va.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 21 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Gordon S. K...</b>							

02508

CERTIFICATE OF DEATH

Attorney

STATE OF NEW YORK

County of ...

City of ...

State of ...

County of ...

City of ...

State of ...

County of ...

City of ...

State of ...

County of ...

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City of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2588

02567

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>1 418 FAYETTE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUTHER</b> Middle <b>PORTER</b> Last <b>SHAFFER</b>				4. DATE OF DEATH Month <b>3/8</b> Day <b>-</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>123 12/31-86</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Co. RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND - BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PERRY SHAFFER</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA PORTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>War I</b>		17. INFORMANT <b>PTS. OLD CHART</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>44-3X</b> IMMEDIATE CAUSE (a) <b>Dissecting Aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis, Severe</b> DUE TO (c) <b>Arteriosclerosis + Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b> <b>5 HRS</b> <b>15 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive + Arteriosclerotic Heart Disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>150 3/8</b> to <b>3/8</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> 19 <b>61</b> , and that death occurred <b>10:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Weisman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>				22d. ADDRESS <b>59 GREENE &amp; Cumberland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-11-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

DR. SIMONS

CERTIFICATE OF DEATH

2589

02568

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN b <b>4 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE L. SHINGLER</b>		First		Middle		Last		4. DATE OF DEATH <b>MARCH 4 19 61</b>		Month		Day		Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 9, 1901</b>		9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>S JOHN SHINGLER</b>		14. MOTHER'S MAIDEN NAME <b>IDA SHILLINGBURG</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart disease</b> (a), stating the underlying cause last. DUE TO <b>Generalized arteriosclerosis</b> (c)														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>314161</b>		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <b>2/28/61</b> 19....., that (I) (we) last saw the deceased alive on <b>3/3</b> 19....., and that death occurred at <b>3:05 A.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>George A. Simons</b>		M.D.		22b. ADDRESS <b>Algonquin Hotel, Cumberland, Md</b>		22c. DATE SIGNED <b>3/4/61</b>									
22d. PHYSICIAN'S NAME (Type) <b>DR. GEORGE A. SIMONS</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sueane Point</b>		23d. LOCATION (City, town or county) <b>Westport</b>		(State) <b>N.V.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boral</b>		ADDRESS <b>Westernport, Md</b>		25a. REC'D BY REGISTRAR <b>Mar 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kruer</b>									



DR. GEORGE A. SIMONS

052804

WEDNESDAY

WEDNESDAY

WEDNESDAY

CHURCHLAND

11 DAYS

WESTERNPORT

MEMORIAL HOSPITAL



GEORGE X

CHURCHLAND

MARCH

01

DATE

WHITE

FEB. 2, 1901

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COAL MINER

WEST VIRGINIA

U.S.A.

2 JOHN SHINDLER

IDA SHILLINGERS

MEMORIAL HOSPITAL - CHURCHLAND, W. VA.

DR. GEORGE A. SIMONS

3:05 A.M.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2590

Items 20b & 20c, Film G-284 4/4/61.cac

Reg. Dist. No. 02569

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Ellerslie, Md.</b>		c. LENGTH OF STAY IN 1b <b>Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1, Oldtown, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Ellerslie, Md.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>EUGENE</b> Last <b>SHIPE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1925</b>		9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lineman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical Power Co.-Springfield, W. Va.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John R. Shipe</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Shipes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>212-24-0544</b>		17. INFORMANT Address <b>Mrs. Jesse Shipe, Oldtown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SKULL FRACTURE, DISLOCATION OF ATLAS; Trans- ection of spinal cord.</b> DUE TO <b>902.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Electrical Power Pole Fell from Telephone Pole</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:35 p. m. March 22 19 61</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <b>Electrical Power Pole Telephone pole near Ellerslie Allegany Md.</b>			
20f. (City or town) <b>Allegany</b>		20g. (County) <b>Allegany</b>		20h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 22, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 26, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon paper.  
VR A15 (4)  
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2591 *Item # 3 - Falm # 282 - 3/8/61 - 7M3*  
CERTIFICATE OF DEATH  
02570

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>423 VIRGINIA AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AMINTA</b>		First Middle Last <b>ALSO KNOWN AS SIMMONS</b>		DATE DEATH <b>MARCH 1 1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 2, 1896</b>		9. AGE (In years last birthday) <b>64</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN W. KEYS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA GILPIN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-7710</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease 2 yrs</b> DUE TO (c) <b>Intestinal Obstruction 4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>28 Feb. 61</b> to <b>1 Mar. 61</b> , that (I) (we) last saw the deceased alive on <b>1 March 1961</b> , and that death occurred <b>8:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James G. Stegmair</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>JAMES G. STEGMAIER</b>		22d. ADDRESS <b>122 SOUTH CENTRE ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem</b>			
23d. LOCATION (City, town or county) <b>Cumberland Md</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumb Md</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							



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258 • J. Neurosci., July 26, 2006 • 26(30):2579–2588

105 SOUTH CENTRE ST., LUMBERTON, N.J.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02571

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Flintstone</b>				c. LENGTH OF STAY IN 1b <b>32 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPHINE VICTORIA SMITH</b>				4. DATE OF DEATH <b>Mar 20 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 20, 1877</b>	
9. AGE (In years lost birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Augusta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>			
13. FATHER'S NAME <b>Lewis Lovett James</b>				14. MOTHER'S MAIDEN NAME <b>Mary Morris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Emory Davis, Flintstone, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO (b) <b>Cardiovascular</b> DUE TO (c) <b>Arteriosclerotic disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 18 1961</b> to <b>Mar 20 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 19 1961</b> , and that death occurred at <b>7:25</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>L M Shaffer</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/22/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>L M SHAFFER MD</b>		22d. ADDRESS <b>Hancock, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 23, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Flintstone, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hofer</b>		ADDRESS <b>230 Balto. Ave. Cumb.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Kraus</b>	

2252

02521

Residence of Deceased

Age of Deceased

Sex of Deceased

Color of Deceased

Place of Birth

Marital Status

Occupation

Education

Religion

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Registrar

Date of Death

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2593 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02572**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>25 YEARS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>303 DECATUR ST.</b>				d. STREET ADDRESS <b>303 DECATUR ST.</b>				
3. NAME OF DECEASED (Type or print) First <b>PAULINE</b> Middle <b>VIRGINIA</b> Last <b>STEGMAIER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>16</b> Year <b>19 61</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 13, 1905</b>		9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTURANT</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>August Newman</b>				14. MOTHER'S MAIDEN NAME <b>Austia Ryan</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 10 8737</b>		17. INFORMANT <b>AUSTIA B. FORD CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>MARCH 16, 1961</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 20, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## 8250

Reg. Dist. No. 02573

**MEDICAL CERTIFICATION**

VS. A15ME(S)  
5M 9/55

2060173 XVI



25250



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2595  
CERTIFICATE OF DEATH  
02574

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>		d. STREET ADDRESS <b>22 DAVIDSON STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>TOMLINSON</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5th</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 4TH, 1896</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASST. CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ALLEG. BALLISTICS</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CECIL TOMLINSON</b>		14. MOTHER'S MAIDEN NAME <b>CHARLOTTE SIRES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW 1</b>		16. SOCIAL SECURITY NO. <b>214-07-0091</b>	
17. INFORMANT Address <b>Mrs. Ora Tomlinson, 22 Davidson St. F'bg. Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> <b>Advanced Carcinoma of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr. 3 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>X</b> Day <b>19</b> Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>3/5 1961</b> , that (I) (we) last saw the deceased alive on <b>3/5 1961</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin M. Rothstein M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN</b>		22d. ADDRESS <b>40 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. P. Dussert</b>		24a. ADDRESS <b>FROSTBURG, MD.</b>	
24b. Sec'd BY REGISTRAR <b>9 '61</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

100-234

CERTIFICATE OF DEATH

100-234

100-234

AL. MEANY

MARTIN

AL. MEANY

PROSECUTOR

100-234

AL. MEANY

SS. DAVIDSON

AL. MEANY

JOHN. J. MEANY

AL. MEANY

DATE: JAN. 10, 1906

AL. MEANY

CHARLOTTE BIRCH

AL. MEANY

100-234

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2596

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02575

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Bedford</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyndman Rural</b> 75 X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>Londonderry Township</b>			
3. NAME OF DECEASED (Type or print) First <b>Albert S.</b> Middle <b>Wambaugh</b> Last <b></b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1961</b> 19			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegrapher &amp; merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Fairhope, Pa. RD 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wambough</b>				14. MOTHER'S MAIDEN NAME <b>Susan Berkey Wambaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-7988</b>		17. INFORMANT Address <b>Mrs. Albert Wambaugh, Hyndman, Pa. RD #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 24, 1961</b>			
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 27, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cooks Mills Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa. RD #1</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigler</b>				ADDRESS <b>Hyndman, Pa.</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

05234

WISCONSIN STATE DEPARTMENT OF HEALTH - MADISON, WIS.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2298

(M)

<p>NAME OF DECEASED JAMES J. JAMES</p>		<p>AGE 45</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH April 15, 1931</p>		<p>PLACE OF DEATH Home</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>MANNER OF DEATH Natural</p>	
<p>LOCALITY OF DEATH City of Madison, Wis.</p>		<p>COUNTY Dane</p>	
<p>RESIDENCE 1234 Main St., Madison, Wis.</p>		<p>DATE OF BIRTH April 15, 1886</p>	
<p>EDUCATION High School Graduate</p>		<p>OCCUPATION Teacher</p>	
<p>RELIGION Roman Catholic</p>		<p>PREVIOUS ILLNESS None</p>	
<p>DATE OF EXAMINATION April 15, 1931</p>		<p>TIME OF EXAMINATION 10:00 AM</p>	
<p>PLACE OF EXAMINATION Home</p>		<p>NAME OF EXAMINER Dr. J. J. James</p>	
<p>SIGNATURE OF EXAMINER J. J. James</p>		<p>DATE April 15, 1931</p>	

(1)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2597

## CERTIFICATE OF DEATH

02576

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>WEST VIRGINIA</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PAW PAW</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>(BABY)</b>		First Middle Last <b>WEAVER</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>MARCH 14 1961</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>MARCH 14, 1961</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>3</b> <b>28</b>		IF UNDER 1 YEAR Months Days Hours Mi. IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>----</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>HARRY F. WEAVER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>BETTY LOU ROBERTSON</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxemia</b> <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of Umbilical Cord</b> DUE TO (c) <b>Congenital Absence of Aortic Heart.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>19</b> <b>8:35AM</b> <b>to</b> <b>19</b> <b>to</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>19</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Fuller B. Whitworth</b> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <b>FULLER B. WHITWORTH</b>				<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <b>123 BEDFORD ST., CUMBERLAND, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>3/15/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodrow Cem.</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Paw Paw, (Morgan) W. Va.</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>PARKS-JOHNSON CO. Berkeley Springs W. Va.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>James L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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WEST VIRGINIA

ALLEGANY

DAY BAY

STEEPLE

MEMORIAL HOSPITAL  
CHOLIC & VARIETAL

MARCH 14 1961

WEAVER

( )

MARCH 14, 1961

WHITE

WHITE

U.S.A.

CUMBERLAND, MARYLAND

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WHITE

BETTY LOU ROBERTSON

HARRY E. WEAVER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

WHITE

WHITE

0:32AM

152 BEDFORD ST., CUMBERLAND, MD.

FULLER E. WINTWORTH

DAY BAY, (CUMBERLAND) V.A.

ROOSTON CEM.

STATION

CUMBERLAND

PARKS-JOHNSON CO. RETAILERS AND WHOLESALE, V.A. HALL 21



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2598

02577

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 HR 45 MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>107 OFFUTT STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>MINNIE WELSH</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>MARCH 6 1961</b>		<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>OCTOBER 27, 1879</b>		<b>9. AGE</b> (In years last birthday) <b>82 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST VIRGINIA</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>ELIJAH RAWLINGS</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ann Hester WELSH</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>				<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis &amp; Sepsis</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)														<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 yrs</b> <b>10 yrs</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from June 1957 to Mar 6, 1961, that (I) (we) last saw the deceased alive on Mar 5 1961, and that death occurred at 2:40 AM on the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <b>Clayton L. Durrett</b> M.D.								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. C. E. DURRETT</b>								<b>22d. ADDRESS</b> <b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>3/8/61</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Vale Summit Meth. Cem.</b>				<b>23d. LOCATION (City, town or county) (State)</b> <b>Vale Summit, Maryland</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Hafer, Cumberland, Maryland</b>								<b>25a. REC'D BY REGISTRAR</b> <b>MAR 9 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

1 PM 25 MIN

CUMBERLAND

107 COTTAGE STREET

MEMORIAL HOSPITAL

107

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BIRMINGHAM

OCTOBER 27, 1942

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U.S.A.

WEST VIRGINIA

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HOUSING

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RAILROADS

RAILROADS

MEMORIAL HOSPITAL - CUMBERLAND, MD.

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MA 06:40

300 VIRGINIA AVE., CUMBERLAND, MD.

DR. G. E. DUBRETT

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MAR 8 '01

107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DR. W.F. WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2599

CERTIFICATE OF DEATH

02578

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>27 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRANTSVILLE</b> d. STREET ADDRESS <b>11X-2</b>											
3. NAME OF DECEASED (Type or print) First <b>ELIZA</b> Middle <b>F.</b> Last <b>WETMILLER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>19 61</b>											
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 11, 1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-KEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>				11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>SAMUEL WETMILLER</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA WEIMER</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>080-24-9768</b>				17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> <b>Arterio sclerotic Cardio-vascular disease (acute circulatory collapse)</b> DUE TO (b) <b>Generalized arterio sclerosis</b> DUE TO (c) <b>Gastric resection for stenosing duodenal ulcer</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>4</b>												INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <b>19 61</b> Hour a.m. <b>11:21</b> p.m. <b>12:00</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-7-61</b> to <b>3-7-61</b> that (I) (we) last saw the deceased alive on <b>3-7-61</b> and that death occurred at <b>12:00 MIDNIGHT</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>W.F. Williams</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>3-8-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>				22d. ADDRESS <b>Cumberland Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>3/10/1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ST-MICHEL'S-CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>SALISBURY-ROD#1-SOMERSET-PA</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stanley M. Thomas</b>				ADDRESS <b>Salisbury, Pa.</b>				25a. REC'D BY REGISTRAR <b>WAR 10'61</b>				25b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

2600

02579

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
c. LENGTH OF STAY IN 1b <b>13 DAYS</b>		d. STREET ADDRESS <b>305 VIRGINIA AVENUE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>WHITNEY</b> Last <b>WHITNEY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>19 61</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 25, 1895</b>			
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>JOSEPH SNYDER</b>		14. MOTHER'S MAIDEN NAME <b>ALICE TRUE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>				
17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized arteriosclerosis</b> (a), stating the underlying cause last, (c) <b>Coronary artery disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>2/21/61</b> to <b>3/8</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> , 19 <b>61</b> , and that death occurred at <b>6:55 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>DR. GEORGE M. SIMONS</b> M.D. 22b. PHYSICIAN'S NAME (Type) <b>DR. GEORGE M. SIMONS</b> 22c. ADDRESS <b>ALGONQUIN HOTEL-CUMBERLAND, MD.</b> 22d. DATE SIGNED 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE 22g. DATE 22h. REGISTRAR'S SIGNATURE 22i. DATE 22j. REGISTRAR'S SIGNATURE 22k. DATE 22l. REGISTRAR'S SIGNATURE 22m. DATE 22n. REGISTRAR'S SIGNATURE 22o. DATE 22p. REGISTRAR'S SIGNATURE 22q. DATE 22r. REGISTRAR'S SIGNATURE 22s. DATE 22t. REGISTRAR'S SIGNATURE 22u. DATE 22v. REGISTRAR'S SIGNATURE 22w. DATE 22x. REGISTRAR'S SIGNATURE 22y. DATE 22z. REGISTRAR'S SIGNATURE 22aa. DATE 22ab. REGISTRAR'S SIGNATURE 22ac. DATE 22ad. REGISTRAR'S SIGNATURE 22ae. DATE 22af. REGISTRAR'S SIGNATURE 22ag. DATE 22ah. REGISTRAR'S SIGNATURE 22ai. DATE 22aj. REGISTRAR'S SIGNATURE 22ak. DATE 22al. REGISTRAR'S SIGNATURE 22am. DATE 22an. REGISTRAR'S SIGNATURE 22ao. DATE 22ap. REGISTRAR'S SIGNATURE 22aq. DATE 22ar. REGISTRAR'S SIGNATURE 22as. DATE 22at. REGISTRAR'S SIGNATURE 22au. DATE 22av. REGISTRAR'S SIGNATURE 22aw. DATE 22ax. REGISTRAR'S SIGNATURE 22ay. DATE 22az. REGISTRAR'S SIGNATURE 22ba. DATE 22bb. REGISTRAR'S SIGNATURE 22bc. DATE 22bd. REGISTRAR'S SIGNATURE 22be. DATE 22bf. REGISTRAR'S SIGNATURE 22bg. DATE 22bh. REGISTRAR'S SIGNATURE 22bi. DATE 22bj. REGISTRAR'S SIGNATURE 22bk. DATE 22bl. REGISTRAR'S SIGNATURE 22bm. DATE 22bn. REGISTRAR'S SIGNATURE 22bo. DATE 22bp. REGISTRAR'S SIGNATURE 22bq. DATE 22br. REGISTRAR'S SIGNATURE 22bs. DATE 22bt. REGISTRAR'S SIGNATURE 22bu. DATE 22bv. REGISTRAR'S SIGNATURE 22bw. DATE 22bx. REGISTRAR'S SIGNATURE 22by. DATE 22bz. REGISTRAR'S SIGNATURE 22ca. DATE 22cb. REGISTRAR'S SIGNATURE 22cc. DATE 22cd. REGISTRAR'S SIGNATURE 22ce. DATE 22cf. REGISTRAR'S SIGNATURE 22cg. DATE 22ch. REGISTRAR'S SIGNATURE 22ci. DATE 22cj. REGISTRAR'S SIGNATURE 22ck. DATE 22cl. REGISTRAR'S SIGNATURE 22cm. DATE 22cn. REGISTRAR'S SIGNATURE 22co. DATE 22cp. REGISTRAR'S SIGNATURE 22cq. DATE 22cr. REGISTRAR'S SIGNATURE 22cs. DATE 22ct. REGISTRAR'S SIGNATURE 22cu. DATE 22cv. REGISTRAR'S SIGNATURE 22cw. DATE 22cx. REGISTRAR'S SIGNATURE 22cy. DATE 22cz. REGISTRAR'S SIGNATURE 22da. DATE 22db. REGISTRAR'S SIGNATURE 22dc. DATE 22dd. REGISTRAR'S SIGNATURE 22de. DATE 22df. REGISTRAR'S SIGNATURE 22dg. DATE 22dh. REGISTRAR'S SIGNATURE 22di. DATE 22dj. REGISTRAR'S SIGNATURE 22dk. DATE 22dl. REGISTRAR'S SIGNATURE 22dm. DATE 22dn. REGISTRAR'S SIGNATURE 22do. DATE 22dp. REGISTRAR'S SIGNATURE 22dq. DATE 22dr. REGISTRAR'S SIGNATURE 22ds. DATE 22dt. REGISTRAR'S SIGNATURE 22du. DATE 22dv. REGISTRAR'S SIGNATURE 22dw. DATE 22dx. REGISTRAR'S SIGNATURE 22dy. DATE 22dz. REGISTRAR'S SIGNATURE 22ea. DATE 22eb. REGISTRAR'S SIGNATURE 22ec. DATE 22ed. 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REGISTRAR'S SIGNATURE 22gc. DATE 22gd. REGISTRAR'S SIGNATURE 22ge. DATE 22gf. REGISTRAR'S SIGNATURE 22gg. DATE 22gh. REGISTRAR'S SIGNATURE 22gi. DATE 22gj. REGISTRAR'S SIGNATURE 22gk. DATE 22gl. REGISTRAR'S SIGNATURE 22gm. DATE 22gn. REGISTRAR'S SIGNATURE 22go. DATE 22gp. REGISTRAR'S SIGNATURE 22gq. DATE 22gr. REGISTRAR'S SIGNATURE 22gs. DATE 22gt. REGISTRAR'S SIGNATURE 22gu. DATE 22gv. REGISTRAR'S SIGNATURE 22gw. DATE 22gx. REGISTRAR'S SIGNATURE 22gy. DATE 22gz. REGISTRAR'S SIGNATURE 22ha. DATE 22hb. REGISTRAR'S SIGNATURE 22hc. DATE 22hd. REGISTRAR'S SIGNATURE 22he. DATE 22hf. REGISTRAR'S SIGNATURE 22hg. DATE 22hh. REGISTRAR'S SIGNATURE 22hi. DATE 22hj. REGISTRAR'S SIGNATURE 22hk. DATE 22hl. REGISTRAR'S SIGNATURE 22hm. DATE 22hn. REGISTRAR'S SIGNATURE 22ho. DATE 22hp. REGISTRAR'S SIGNATURE 22hq. DATE 22hr. REGISTRAR'S SIGNATURE 22hs. DATE 22ht. REGISTRAR'S SIGNATURE 22hu. DATE 22hv. REGISTRAR'S SIGNATURE 22hw. DATE 22hx. REGISTRAR'S SIGNATURE 22hy. DATE 22hz. REGISTRAR'S SIGNATURE 22ia. DATE 22ib. REGISTRAR'S SIGNATURE 22ic. DATE 22id. REGISTRAR'S SIGNATURE 22ie. DATE 22if. REGISTRAR'S SIGNATURE 22ig. DATE 22ih. REGISTRAR'S SIGNATURE 22ii. DATE 22ij. REGISTRAR'S SIGNATURE 22ik. DATE 22il. REGISTRAR'S SIGNATURE 22im. DATE 22in. REGISTRAR'S SIGNATURE 22io. DATE 22ip. REGISTRAR'S SIGNATURE 22iq. DATE 22ir. REGISTRAR'S SIGNATURE 22is. DATE 22it. REGISTRAR'S SIGNATURE 22iu. DATE 22iv. REGISTRAR'S SIGNATURE 22iw. DATE 22ix. REGISTRAR'S SIGNATURE 22iy. DATE 22iz. REGISTRAR'S SIGNATURE 22ja. DATE 22jb. REGISTRAR'S SIGNATURE 22jc. DATE 22jd. REGISTRAR'S SIGNATURE 22je. DATE 22jf. REGISTRAR'S SIGNATURE 22jg. DATE 22jh. REGISTRAR'S SIGNATURE 22ji. DATE 22jj. REGISTRAR'S SIGNATURE 22jk. DATE 22jl. REGISTRAR'S SIGNATURE 22jm. DATE 22jn. REGISTRAR'S SIGNATURE 22jo. DATE 22jp. REGISTRAR'S SIGNATURE 22jq. DATE 22jr. REGISTRAR'S SIGNATURE 22js. DATE 22jt. REGISTRAR'S SIGNATURE 22ju. DATE 22jv. REGISTRAR'S SIGNATURE 22jw. DATE 22jx. REGISTRAR'S SIGNATURE 22jy. DATE 22jz. REGISTRAR'S SIGNATURE 22ka. DATE 22kb. REGISTRAR'S SIGNATURE 22kc. DATE 22kd. REGISTRAR'S SIGNATURE 22ke. DATE 22kf. REGISTRAR'S SIGNATURE 22kg. DATE 22kh. REGISTRAR'S SIGNATURE 22ki. DATE 22kj. REGISTRAR'S SIGNATURE 22kk. DATE 22kl. REGISTRAR'S SIGNATURE 22km. DATE 22kn. REGISTRAR'S SIGNATURE 22ko. DATE 22kp. REGISTRAR'S SIGNATURE 22kq. DATE 22kr. REGISTRAR'S SIGNATURE 22ks. DATE 22kt. REGISTRAR'S SIGNATURE 22ku. DATE 22kv. REGISTRAR'S SIGNATURE 22kw. DATE 22kx. REGISTRAR'S SIGNATURE 22ky. DATE 22kz. REGISTRAR'S SIGNATURE 22la. DATE 22lb. REGISTRAR'S SIGNATURE 22lc. DATE 22ld. REGISTRAR'S SIGNATURE 22le. DATE 22lf. REGISTRAR'S SIGNATURE 22lg. DATE 22lh. REGISTRAR'S SIGNATURE 22li. DATE 22lj. REGISTRAR'S SIGNATURE 22lk. DATE 22ll. REGISTRAR'S SIGNATURE 22lm. DATE 22ln. REGISTRAR'S SIGNATURE 22lo. DATE 22lp. REGISTRAR'S SIGNATURE 22lq. DATE 22lr. REGISTRAR'S SIGNATURE 22ls. DATE 22lt. REGISTRAR'S SIGNATURE 22lu. DATE 22lv. REGISTRAR'S SIGNATURE 22lw. DATE 22lx. REGISTRAR'S SIGNATURE 22ly. DATE 22lz. REGISTRAR'S SIGNATURE 22ma. DATE 22mb. REGISTRAR'S SIGNATURE 22mc. DATE 22md. REGISTRAR'S SIGNATURE 22me. DATE 22mf. REGISTRAR'S SIGNATURE 22mg. DATE 22mh. REGISTRAR'S SIGNATURE 22mi. DATE 22mj. REGISTRAR'S SIGNATURE 22mk. DATE 22ml. REGISTRAR'S SIGNATURE 22mm. DATE 22mn. REGISTRAR'S SIGNATURE 22mo. DATE 22mp. REGISTRAR'S SIGNATURE 22mq. DATE 22mr. REGISTRAR'S SIGNATURE 22ms. DATE 22mt. REGISTRAR'S SIGNATURE 22mu. DATE 22mv. REGISTRAR'S SIGNATURE 22mw. DATE 22mx. REGISTRAR'S SIGNATURE 22my. DATE 22mz. REGISTRAR'S SIGNATURE 22na. DATE 22nb. REGISTRAR'S SIGNATURE 22nc. DATE 22nd. REGISTRAR'S SIGNATURE 22ne. DATE 22nf. REGISTRAR'S SIGNATURE 22ng. DATE 22nh. REGISTRAR'S SIGNATURE 22ni. DATE 22nj. REGISTRAR'S SIGNATURE 22nk. DATE 22nl. REGISTRAR'S SIGNATURE 22nm. DATE 22nn. REGISTRAR'S SIGNATURE 22no. DATE 22np. REGISTRAR'S SIGNATURE 22nq. DATE 22nr. REGISTRAR'S SIGNATURE 22ns. DATE 22nt. REGISTRAR'S SIGNATURE 22nu. DATE 22nv. REGISTRAR'S SIGNATURE 22nw. DATE 22nx. REGISTRAR'S SIGNATURE 22ny. DATE 22nz. REGISTRAR'S SIGNATURE 22oa. DATE 22ob. REGISTRAR'S SIGNATURE 22oc. DATE 22od. REGISTRAR'S SIGNATURE 22oe. DATE 22of. REGISTRAR'S SIGNATURE 22og. DATE 22oh. REGISTRAR'S SIGNATURE 22oi. DATE 22oj. REGISTRAR'S SIGNATURE 22ok. DATE 22ol. REGISTRAR'S SIGNATURE 22om. DATE 22on. REGISTRAR'S SIGNATURE 22oo. DATE 22op. REGISTRAR'S SIGNATURE 22oq. DATE 22or. REGISTRAR'S SIGNATURE 22os. DATE 22ot. REGISTRAR'S SIGNATURE 22ou. DATE 22ov. REGISTRAR'S SIGNATURE 22ow. DATE 22ox. REGISTRAR'S SIGNATURE 22oy. DATE 22oz. REGISTRAR'S SIGNATURE 22pa. DATE 22pb. REGISTRAR'S SIGNATURE 22pc. DATE 22pd. REGISTRAR'S SIGNATURE 22pe. DATE 22pf. REGISTRAR'S SIGNATURE 22pg. DATE 22ph. REGISTRAR'S SIGNATURE 22pi. DATE 22pj. REGISTRAR'S SIGNATURE 22pk. DATE 22pl. REGISTRAR'S SIGNATURE 22pm. DATE 22pn. REGISTRAR'S SIGNATURE 22po. DATE 22pp. REGISTRAR'S SIGNATURE 22pq. DATE 22pr. 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REGISTRAR'S SIGNATURE 22rq. DATE 22rr. REGISTRAR'S SIGNATURE 22rs. DATE 22rt. REGISTRAR'S SIGNATURE 22ru. DATE 22rv. REGISTRAR'S SIGNATURE 22rw. DATE 22rx. REGISTRAR'S SIGNATURE 22ry. DATE 22rz. REGISTRAR'S SIGNATURE 22sa. DATE 22sb. REGISTRAR'S SIGNATURE 22sc. DATE 22sd. REGISTRAR'S SIGNATURE 22se. DATE 22sf. REGISTRAR'S SIGNATURE 22sg. DATE 22sh. REGISTRAR'S SIGNATURE 22si. DATE 22sj. REGISTRAR'S SIGNATURE 22sk. DATE 22sl. REGISTRAR'S SIGNATURE 22sm. DATE 22sn. REGISTRAR'S SIGNATURE 22so. DATE 22sp. REGISTRAR'S SIGNATURE 22sq. DATE 22sr. REGISTRAR'S SIGNATURE 22ss. DATE 22st. REGISTRAR'S SIGNATURE 22su. DATE 22sv. REGISTRAR'S SIGNATURE 22sw. DATE 22sx. REGISTRAR'S SIGNATURE 22sy. DATE 22sz. REGISTRAR'S SIGNATURE 22ta. DATE 22tb. REGISTRAR'S SIGNATURE 22tc. DATE 22td. REGISTRAR'S SIGNATURE 22te. DATE 22tf. REGISTRAR'S SIGNATURE 22tg. DATE 22th. REGISTRAR'S SIGNATURE 22ti. DATE 22tj. REGISTRAR'S SIGNATURE 22tk. DATE 22tl. REGISTRAR'S SIGNATURE 22tm. DATE 22tn. REGISTRAR'S SIGNATURE 22to. DATE 22tp. REGISTRAR'S SIGNATURE 22tq. DATE 22tr. REGISTRAR'S SIGNATURE 22ts. DATE 22tt. REGISTRAR'S SIGNATURE 22tu. DATE 22tv. REGISTRAR'S SIGNATURE 22tw. DATE 22tx. REGISTRAR'S SIGNATURE 22ty. DATE 22tz. REGISTRAR'S SIGNATURE 22ua. DATE 22ub. REGISTRAR'S SIGNATURE 22uc. DATE 22ud. REGISTRAR'S SIGNATURE 22ue. DATE 22uf. REGISTRAR'S SIGNATURE 22ug. DATE 22uh. REGISTRAR'S SIGNATURE 22ui. DATE 22uj. REGISTRAR'S SIGNATURE 22uk. DATE 22ul. REGISTRAR'S SIGNATURE 22um. DATE 22un. REGISTRAR'S SIGNATURE 22uo. DATE 22up. REGISTRAR'S SIGNATURE 22uq. DATE 22ur. REGISTRAR'S SIGNATURE 22us. DATE 22ut. REGISTRAR'S SIGNATURE 22uu. DATE 22uv. REGISTRAR'S SIGNATURE 22uw. DATE 22ux. REGISTRAR'S SIGNATURE 22uy. DATE 22uz. REGISTRAR'S SIGNATURE 22va. DATE 22vb. REGISTRAR'S SIGNATURE 22vc. DATE 22vd. REGISTRAR'S SIGNATURE 22ve. DATE 22vf. REGISTRAR'S SIGNATURE 22vg. DATE 22vh. REGISTRAR'S SIGNATURE 22vi. DATE 22vj. REGISTRAR'S SIGNATURE 22vk. DATE 22vl. REGISTRAR'S SIGNATURE 22vm. DATE 22vn. REGISTRAR'S SIGNATURE 22vo. DATE 22vp. REGISTRAR'S SIGNATURE 22vq. DATE 22vr. REGISTRAR'S SIGNATURE 22vs. DATE 22vt. REGISTRAR'S SIGNATURE 22vu. DATE 22vv. REGISTRAR'S SIGNATURE 22vw. DATE 22vx. REGISTRAR'S SIGNATURE 22vy. DATE 22vz. REGISTRAR'S SIGNATURE 22wa. DATE 22wb. REGISTRAR'S SIGNATURE 22wc. DATE 22wd. REGISTRAR'S SIGNATURE 22we. DATE 22wf. REGISTRAR'S SIGNATURE 22wg. DATE 22wh. REGISTRAR'S SIGNATURE 22wi. DATE 22wj. REGISTRAR'S SIGNATURE 22wk. DATE 22wl. REGISTRAR'S SIGNATURE 22wm. DATE 22wn. REGISTRAR'S SIGNATURE 22wo. DATE 22wp. REGISTRAR'S SIGNATURE 22wq. DATE 22wr. REGISTRAR'S SIGNATURE 22ws. DATE 22wt. REGISTRAR'S SIGNATURE 22wu. DATE 22wv. REGISTRAR'S SIGNATURE 22ww. DATE 22wx. REGISTRAR'S SIGNATURE 22wy. DATE 22wz. REGISTRAR'S SIGNATURE 22xa. DATE 22xb. REGISTRAR'S SIGNATURE 22xc. DATE 22xd. REGISTRAR'S SIGNATURE 22xe. DATE 22xf. REGISTRAR'S SIGNATURE 22xg. DATE 22xh. REGISTRAR'S SIGNATURE 22xi. DATE 22xj. REGISTRAR'S SIGNATURE 22xk. DATE 22xl. REGISTRAR'S SIGNATURE 22xm. DATE 22xn. REGISTRAR'S SIGNATURE 22xo. DATE 22xp. REGISTRAR'S SIGNATURE 22xq. DATE 22xr. REGISTRAR'S SIGNATURE 22xs. DATE 22xt. REGISTRAR'S SIGNATURE 22xu. DATE 22xv. REGISTRAR'S SIGNATURE 22xw. DATE 22xx. REGISTRAR'S SIGNATURE 22xy. DATE 22xz. REGISTRAR'S SIGNATURE 22ya. DATE 22yb. REGISTRAR'S SIGNATURE 22yc. DATE 22yd. REGISTRAR'S SIGNATURE 22ye. DATE 22yf. REGISTRAR'S SIGNATURE 22yg. DATE 22yh. REGISTRAR'S SIGNATURE 22yi. DATE 22yj. REGISTRAR'S SIGNATURE 22yk. DATE 22yl. REGISTRAR'S SIGNATURE 22ym. DATE 22yn. REGISTRAR'S SIGNATURE 22yo. DATE 22yp. REGISTRAR'S SIGNATURE 22yq. DATE 22yr. REGISTRAR'S SIGNATURE 22ys. DATE 22yt. REGISTRAR'S SIGNATURE 22yu. DATE 22yv. REGISTRAR'S SIGNATURE 22yw. DATE 22yx. REGISTRAR'S SIGNATURE 22yy. DATE 22yz. REGISTRAR'S SIGNATURE 22za. DATE 22zb. REGISTRAR'S SIGNATURE 22zc. DATE 22zd. REGISTRAR'S SIGNATURE 22ze. DATE 22zf. REGISTRAR'S SIGNATURE 22zg. DATE 22zh. REGISTRAR'S SIGNATURE 22zi. DATE 22zj. REGISTRAR'S SIGNATURE 22zk. DATE 22zl. REGISTRAR'S SIGNATURE 22zm. DATE 22zn. REGISTRAR'S SIGNATURE 22zo. DATE 22zp. REGISTRAR'S SIGNATURE 22zq. DATE 22zr. REGISTRAR'S SIGNATURE 22zs. DATE 22zt. REGISTRAR'S SIGNATURE 22zu. DATE 22zv. REGISTRAR'S SIGNATURE 22zw. DATE 22zx. REGISTRAR'S SIGNATURE 22zy. DATE 22zz. REGISTRAR'S SIGNATURE 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Mar. 11, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

02579

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ALLEGANY

WYOMING

ALLEGANY

CUMBERLAND

13 DAYS

CUMBERLAND

305 VIRGINIA AVENUE

MEMORIAL & HARRISON WES.

MEMORIAL HOSPITAL

61

8

MARCH

WHITNEY

10

68

APRIL 22, 1907

FEMALE WHITE

C. S. A.

PENNSYLVANIA

OWN HOME

HOUSE LIT

ALICE TRUE

JOSEPH BRYDER



MEMORIAL HOSPITAL-CUMBERLAND, MD.

NO

1907

ALLEGANY HOSPITAL-CUMBERLAND, MD.

DR. GEORGE H. SIMONS  
XXXXXXXXXXXXXXXXXXXX

CUMBERLAND, MD.

MAR. 11, 1981 Xion Memorial Park

Partial

James T. Scott, III, Cumberland, Md.